

		FOR BHF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0016634</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																							
<b>Facility Name:</b> <u>Clayton Residential Home</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																							
<b>Address:</b> <u>2026 North Clark Street</u> <u>Chicago</u> <u>60614</u>																									
<div>NumberCityZip Code</div>																									
<b>County:</b> <u>Cook</u>																									
<b>Telephone Number:</b> <u>(773) 549-1840</u> <b>Fax #</b> <u>(773) 549-2036</u>																									
<b>HFS ID Number:</b> <u>362607443001</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td></tr><tr><td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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<b>Date of Initial License for Current Owners:</b> <u>00/00/69</u>																									
<b>Type of Ownership:</b>																									
<table><tr><td><input type="checkbox"/> VOLUNTARY,NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td><b>IRS Exemption Code</b> _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input type="checkbox"/> VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____	
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	<input type="checkbox"/> Limited Liability Co.																								
	<input type="checkbox"/> Trust																								
	<input type="checkbox"/> Other _____																								
<b>In the event there are further questions about this report, please contact:</b>																									
<b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clayton Residential Home

# 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	247	Intermediate (ICF)	247	90,155	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	247	TOTALS	247	90,155	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	82,462	92		82,554	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	82,462	92		82,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

D. How many bed-hold days during this year were paid by the Department?

1,279 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

I. On what date did you start providing long term care at this location?

Date started 11/28/66

J. Was the facility purchased or leased after January 1, 1978?

YES NO X

K. Was the facility certified for Medicare during the reporting year?

YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	231,721	26,680	13,800	272,201		272,201		272,201			1
2	Food Purchase		368,711		368,711	(10,512)	358,199	(4)	358,195			2
3	Housekeeping	327,422	51,416		378,838		378,838		378,838			3
4	Laundry		8,227	108,548	116,775		116,775		116,775			4
5	Heat and Other Utilities			175,719	175,719		175,719	2,882	178,601			5
6	Maintenance	206,040		128,614	334,654		334,654	1,504	336,158			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	765,183	455,034	426,681	1,646,898	(10,512)	1,636,386	4,382	1,640,768			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,374,223	34,330	58,658	1,467,211		1,467,211		1,467,211			10
10a	Therapy											10a
11	Activities	147,066	21,995		169,061		169,061		169,061			11
12	Social Services	706,414	600,000	26,310	1,332,724		1,332,724	(600,000)	732,724			12
13	CNA Training			669	669		669		669			13
14	Program Transportation			17,915	17,915		17,915		17,915			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,227,703	656,325	105,952	2,989,980		2,989,980	(600,000)	2,389,980			16
	<b>C. General Administration</b>											
17	Administrative	294,537		873,051	1,167,588		1,167,588	(873,051)	294,537			17
18	Directors Fees			210,000	210,000		210,000	(150,000)	60,000			18
19	Professional Services			94,801	94,801		94,801	(63,267)	31,534			19
20	Dues, Fees, Subscriptions & Promotions			31,906	31,906		31,906	(16,315)	15,591			20
21	Clerical & General Office Expenses	491,955	2,543	36,249	530,747		530,747	(220,051)	310,696			21
22	Employee Benefits & Payroll Taxes			650,516	650,516	10,512	661,028		661,028			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,188	2,188		2,188		2,188			24
25	Other Admin. Staff Transportation			826	826		826		826			25
26	Insurance-Prop.Liab.Malpractice			220,905	220,905		220,905	303	221,208			26
27	Other (specify):*							6,216	6,216			27
28	<b>TOTAL General Administration</b>	786,492	2,543	2,120,442	2,909,477	10,512	2,919,989	(1,316,165)	1,603,824			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,779,378	1,113,902	2,653,075	7,546,355		7,546,355	(1,911,783)	5,634,572			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Clayton Residential Home #0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			140,584	140,584		140,584	49,017	189,601			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,831	128,831		128,831	(42,812)	86,019			32
33	Real Estate Taxes			268,813	268,813		268,813	6,256	275,069			33
34	Rent-Facility & Grounds			30,305	30,305		30,305	(11,923)	18,382			34
35	Rent-Equipment & Vehicles			19,766	19,766		19,766		19,766			35
36	Other (specify):*			32,841	32,841		32,841		32,841			36
37	<b>TOTAL Ownership</b>			621,140	621,140		621,140	538	621,678			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,233	135,233		135,233		135,233			42
43	Other (specify):*	18,945		1,167	20,112		20,112	(20,112)				43
44	<b>TOTAL Special Cost Centers</b>	18,945		136,400	155,345		155,345	(20,112)	135,233			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,798,323	1,113,902	3,410,615	8,322,840		8,322,840	(1,931,357)	6,391,483			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,489)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,017	30		9
10	Interest and Other Investment Income	(42,936)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(275)	21		18
19	Entertainment	(3,824)	21		19
20	Contributions	(13,202)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,926,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,938,869)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	7,512		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 7,512		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,931,357)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Clarton Residential Home			
ID# 0016634			
Report Period Beginning:	01/01/05		
Ending:	12/31/05		
			Sch. V Line
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1	Miscellaneous Income	\$ (41)	21 1
2	Marketing Salary	(18,945)	43 2
3	Marketing Expense	(1,167)	43 3
4	Bank Charges	(850)	21 4
5	Trust Fees	(150)	21 5
6	Other Professional Fees - Barton Management	(63,593)	19 6
7	Non-Allowable Legal	(143)	19 7
8	Management Fees	(873,051)	17 8
9	Non-Allowable Salary	(215,093)	21 9
10	Non-Allowable Director's Fees	(150,000)	18 10
11	CYPE Dues	(3,163)	20 11
12	Non-Allowable Expense	(600,000)	12 12
13			13
14			14
15			15
16			16
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97			97
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99			99
100			100
101	Total	(1,928,150)	101

## Summary A

**12/31/05**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☒ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 2,882	\$ 2,882	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		2,993	2,993	16
17	V	20	DUES, FEES, SUBSCRIPTIONS		BARTON MANAGEMENT INC.		7	7	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		142	142	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		303	303	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		6,216	6,216	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		6,256	6,256	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		18,077	18,077	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	30,000	BARTON MANAGEMENT INC.			(30,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,000			\$ 36,876	\$ * 6,876	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☒ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	BARTON HEALTHCARE LLC	100.00%	\$ 469	\$ 469	15
16	V	20	DUES, SUBSCRIPTIONS		BARTON HEALTHCARE LLC		43	43	16
17	V	32	INTEREST		BARTON HEALTHCARE LLC		128,955	128,955	17
18	V								18
19	V								19
20	V								20
21	V	32	INTEREST	128,831	BARTON HEALTHCARE LLC			(128,831)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 128,831			\$ 129,467	\$ * 636	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☐ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☐ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☐ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☐ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Stockholder	Administrative	6.29%	See Attached	9.00	18.00%		\$		1
2	John Shlofrock	Stockholder	Administrative	5.52%	See Attached	5.00	10.42%	Facility	23,333	17-1	2
3	Paul Magit	Stockholder	Administrative	7.05%	See Attached	10.00	22.22%	Fac, Dir Fee	55,000	17-1, 18-3	3
4	Elisa Shlofrock-Zusman	Stockholder	Clerical	5.52%	See Attached	6.00	14.29%	Facility	3,000	21-1	4
5	David Becker	Stockholder	Administrative	9.52%	None	1.00	2.86%	Director Fees	30,000	18-3	5
6	Jean Shlofrock	Relative	Clerical	0.00%	See Attached	8.00	20.00%	Facility	13,333	21-1	6
7	Jeff Stinebiser	Stockholder	Social Service	5.71%	None	5.00	14.29%	Facility	24,000	12-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 148,666		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BARTON MANAGEMENT INC.  
Street Address 465 CENTRAL AVE.  
City / State / Zip Code NORTHFIELD, IL 60093  
Phone Number ( 847) 441-8200  
Fax Number ( 847) 441-0800

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	218,800	8	\$ 15,766	\$	40,000	\$ 2,882	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	218,800	8	16,372		40,000	2,993	2
3	20	DUES, FEES, SUBSCRIPTIONS	RENTAL INCOME	218,800	8	40		40,000	7	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	218,800	8	777		40,000	142	4
5	26	INSURANCE	RENTAL INCOME	218,800	8	1,656		40,000	303	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	218,800	8	34,000		40,000	6,216	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	218,800	8	34,220		40,000	6,256	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	218,800	8	98,882		40,000	18,077	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 201,713	\$		\$ 36,876	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BARTON HEALTHCARE LLC  
Street Address 465 CENTRAL AVE.  
City / State / Zip Code NORTHFIELD, IL 60093  
Phone Number ( 847) 441-8200  
Fax Number ( 847) 441-0800

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	29	7	\$ 2,760	\$	5	\$ 469	1
2	20	DUES, SUBSCRIPTIONS	NOTE RECEIVABLE	29	7	250		5	43	2
3	32	INTEREST	NOTE RECEIVABLE	29	7	758,257		5	128,955	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 761,267	\$		\$ 129,467	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Barton HealthCare LLC		X	Mortgage	\$20,833.00	1/27/95	\$ 5,000,000	\$ 2,250,044			\$ 128,955	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6												6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$20,833.00		\$ 5,000,000	\$ 2,250,044			\$ 128,955	9	
	B. Non-Facility Related*												
10	Interest Income		X								(42,936)	10	
11												11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (42,936)	14	
15	TOTALS (line 9+line14)						\$ 5,000,000	\$ 2,250,044			\$ 86,019	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$	\$			1
2											2
3											3
4											4
5											5
6											6
7	TOTAL Long-Term										7
	Working Capital										
8							\$	\$			8
9											9
10											10
11											11
12											12
13											13
14	TOTAL Working Capital										14
	B. Non-Facility Related*										
15							\$	\$			15
16											16
17											17
18											18
19											19
20	TOTAL Non-Facility Related										20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clayton Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016634

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-33-208-008-000	Long Term Care Property	\$ 262,530.28	\$ 262,530.28
2. 05-19-112-017-0000	Home Office Allocation	\$ 34,219.61	\$ 6,256.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 296,749.89	\$ 268,786.28

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clayton Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016634

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,604

B. General Construction Type: Exterior Frame

Number of Stories 5

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	17,608		\$ 19,250	1
2					2
3	TOTALS	17,608		\$ 19,250	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1967	\$ 255,750	\$		\$	\$	\$ 240,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1969	591,996		20			591,996	9
10	Various			1971	1,150		20			732	10
11	Various			1972	86,256		20			58,370	11
12	Various			1975	15,890		20			14,000	12
13	Various			1978	11,746		20			11,746	13
14	Various			1979	9,036		20			9,036	14
15	Various			1980	45,469		20			44,529	15
16	Various			1981	17,720		20			17,720	16
17	Various			1982	718		20			718	17
18	Various			1983	57,392		20			57,392	18
19	Various			1984	48,928		20	371	371	47,590	19
20	Various			1985	100,852		20			100,851	20
21	Various			1986	156,306		20	1,715	1,715	156,230	21
22	Various			1987	25,101		20	1,137	1,137	22,540	22
23	Various			1988	16,259		20	711	711	14,632	23
24	Various			1989	23,627		20	659	659	19,393	24
25	Various			1990	183,167		20	8,035	8,035	131,164	25
26	Various			1991	53,962		20	2,700	2,700	39,580	26
27	Various			1992	158,472		20	7,923	7,923	112,878	27
28	Various			1993	79,548		20	3,977	3,977	49,585	28
29	Various			1994	105,602		20	5,281	5,281	61,262	29
30	Various			1995	221,995		20	11,099	11,099	118,666	30
31	Various			1996	237,569		20	11,880	11,880	111,672	31
32	Various			1997	81,461		20	4,074	4,074	33,845	32
33	Various			1998	159,916		20	7,996	7,996	62,268	33
34	Various			1999	195,522		20	9,781	9,781	64,785	34
35	Various			2000	393,212		20	19,662	19,662	112,227	35
36	Various			2001	194,173		20	4,977	4,977	23,300	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)							67
68	Related Party Allocations (Pages 12-REP & 12A-REP)							68
69	Financial Statement Depreciation		140,584			(140,584)		69
70	TOTAL (lines 4 thru 69)	\$	3,528,795	\$	101,978	\$	(38,606)	\$ 2,328,707 70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,528,795	\$ 140,584		\$ 101,978	\$ (38,606)	\$ 2,328,707	1
2	Electrical Work	2002	17,000		20	1,700	1,700	6,800	2
3	Pump-Sprinkler System	2002	3,806		20	381	381	1,269	3
4	Evaporator-Wal-In Cooler	2002	2,504		20	250	250	835	4
5	Broken Tiles Replaced	2002	7,200		20	720	720	2,400	5
6	Radiators-Return Line	2002	3,885		20	389	389	1,230	6
7	Inspect Sewer Line	2002	480		20	48	48	152	7
8	Rodding Of Adm Bathroom	2002	250		20	25	25	79	8
9	Clear Sewer Line	2002	210		20	21	21	67	9
10	Inside Excavation	2002	6,200		20	620	620	1,963	10
11	Continuing Excavation	2002	6,238		20	624	624	1,923	11
12	Continuing Excavation	2002	3,914		20	391	391	1,207	12
13	Excavation-Grout Injection	2002	24,105		20	2,411	2,411	7,432	13
14	Dig Site-Dirt Removal	2002	624		20	62	62	192	14
15	Excavate-Replace Sewer	2002	4,786		20	479	479	1,476	15
16	Exhaust Fan	2003	668		20	134	134	401	16
17	Valve Suppression Panel	2003	5,930		20	1,186	1,186	3,459	17
18	Safeguard Sheet Vinyl	2003	11,367		20	568	568	1,658	18
19	Fire Doors & Frames	2003	1,584		20	79	79	231	19
20	Renovate 5Th Floor	2003	73,200		20	3,660	3,660	10,675	20
21	Painting 514 Flr Office	2003	2,200		20	220	220	587	21
22	1St Flr Conference Room	2003	19,400		20	3,880	3,880	10,347	22
23	Carpet	2003	1,800		20	360	360	960	23
24	Fire System	2003	41,680		20	8,336	8,336	21,535	24
25	Carpets	2003	4,209		20	842	842	2,175	25
26	Misc Remodeling	2003	18,250		20	3,650	3,650	9,429	26
27	Smoke Detection Inspection	2003	2,470		20	494	494	1,029	27
28	Write Off 2000 Invoice	2003	(6,276)		20	(314)	(314)	(941)	28
29	Two Steel Doors	2004	4,250		20	425	425	815	29
30	Carpet	2004	3,017		20	302	302	478	30
31	Carpet	2004	3,699		20	370	370	555	31
32	Carpet	2004	3,773		20	377	377	566	32
33	Masonrv. Bathrm Repairs	2004	33,000		20	3,300	3,300	4,950	33
34	TOTAL (lines 1 thru 33)		\$ 3,834,218	\$ 140,584		\$ 137,968	\$ (2,616)	\$ 2,424,641	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,834,218	\$ 140,584		\$ 137,968	\$ (2,616)	\$ 2,424,641	1
2	Bathroom Repairs	2004	10,500		20	1,050	1,050	1,488	2
3	Bathroom Repairs	2004	3,900		20	390	390	488	3
4	Building Construction Work	2004			20				4
5	Demolition	2004	5,900		20	590	590	1,180	5
6	Framing	2004	7,800		20	780	780	1,560	6
7	Electrical	2004	8,200		20	820	820	1,640	7
8	Ductwork	2004	2,800		20	280	280	560	8
9	Drywall	2004	6,200		20	620	620	1,240	9
10	Flooring	2004	16,000		20	1,600	1,600	3,200	10
11	Woodwork	2004	18,000		20	1,800	1,800	3,600	11
12	Dropceiling	2004	6,600		20	660	660	1,320	12
13	Bathroom Remodeling	2005	5,300		20	486	486	486	13
14	Office Area Demolition	2005	4,900		20	449	449	449	14
15	Two Steel Doors	2005	29,807		20	2,732	2,732	2,732	15
16	Floor Tile Restrooms	2005	720		20	60	60	60	16
17	Office Area Remodeling	2005	75,000		20	5,625	5,625	5,625	17
18	Panels	2005	786		20	59	59	59	18
19	Floor Tile	2005	720		20	48	48	48	19
20	Rooftop A/C	2005	14,843		20	866	866	866	20
21	Hot Water Heater	2005	10,553		20	616	616	616	21
22	Carpets	2005	8,680		20	434	434	434	22
23	A/C Unit	2005	4,407		20	220	220	220	23
24	Emergency Exit Fixture	2005	16,800		20	700	700	700	24
25	Flooring	2005	777		20	13	13	13	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,093,411	\$ 140,584		\$ 158,866	\$ 18,282	\$ 2,453,225	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 516,696	\$	\$ 25,521	\$ 25,521	10	\$ 427,040	71
72	Current Year Purchases	59,783		3,344	3,344	10	3,344	72
73	Fully Depreciated Assets	341,358				10	341,358	73
74								74
75	TOTALS	\$ 917,837	\$	\$ 28,865	\$ 28,865		\$ 771,742	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD E350	2002	\$ 14,521	\$	\$ 1,870	\$ 1,870	5	\$ 7,666	76
77										77
78										78
79										79
80	TOTALS			\$ 14,521	\$	\$ 1,870	\$ 1,870		\$ 7,666	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,045,019	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,584	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,601	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,017	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,232,633	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Barton Management Allocation				18,077			5
6	Storage Rental				305			6
7	TOTAL				\$ 18,382			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 19,766
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☒

120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 569	\$	\$ 569
2	Books and Supplies		100		100
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 669	\$	\$ 669
10	SUM OF line 9, col. 1 and 2 (e)	\$ 669			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
							1	2	3	
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,458,911	\$	1
2	Cash-Patient Deposits	7,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,388,838		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	341,575		5
6	Prepaid Insurance	101,950		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100,000		8
9	Other(specify): See Attached Schedule	150,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,548,274	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,250		13
14	Buildings, at Historical Cost	255,750		14
15	Leasehold Improvements, at Historical Cost	3,551,153		15
16	Equipment, at Historical Cost	1,105,999		16
17	Accumulated Depreciation (book methods)	(2,936,739)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	57,413		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,052,826	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,601,100	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 122,880	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,451		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,969		31
32	Accrued Real Estate Taxes(Sch.IX-B)	270,406		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,580		35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 511,286	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,250,044		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,250,044	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,761,330	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,839,770	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,601,100	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,455,130	1
2	Restatements (describe):		2
3	Depreciation Expense	30,702	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,485,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	353,938	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 353,938	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,839,770	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clayton Residential Home # 0016634 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,632,602	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,632,602	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,239	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,239	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,936	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,936	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,676,778	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,646,898	31
32	Health Care	2,989,980	32
33	General Administration	2,909,477	33
	B. Capital Expense		
34	Ownership	621,140	34
	C. Ancillary Expense		
35	Special Cost Centers	20,112	35
36	Provider Participation Fee	135,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,322,840	40
41	Income before Income Taxes (line 30 minus line 40)**	353,938	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 353,938	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 73,525	\$ 35.35	1
2	Assistant Director of Nursing	320	390	7,993	20.49	2
3	Registered Nurses	13,210	14,612	369,145	25.26	3
4	Licensed Practical Nurses	7,551	7,958	160,164	20.13	4
5	CNAs & Orderlies	68,914	77,125	729,068	9.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,166	15,765	147,066	9.33	10
11	Social Service Workers	37,980	41,040	706,414	17.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,810	25,633	231,721	9.04	15
16	Dishwashers					16
17	Maintenance Workers	17,465	18,308	206,040	11.25	17
18	Housekeepers	32,173	35,618	327,422	9.19	18
19	Laundry					19
20	Administrator	2,080	2,080	98,433	47.32	20
21	Assistant Administrator	2,080	2,080	40,789	19.61	21
22	Other Administrative	2,988	2,988	155,315	51.98	22
23	Office Manager					23
24	Clerical	26,320	27,776	491,955	17.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,032	2,275	34,328	15.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,008	1,122	18,945	16.89	33
34	TOTAL (lines 1 - 33)	253,177	276,850	\$ 3,798,323 *	\$ 13.72	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	276	\$ 13,800	01-03	35
36	Medical Director	112	2,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	695	24,310	12-03	45
46	Other(specify)				46
47	Psychiatric Director Consultant	Monthly	2,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	1,179	\$ 44,310		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,895	56,858	10-03	52
53	TOTAL (lines 50 - 52)	1,895	\$ 56,858		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Barbara Thomas	Administrator	0	\$ 98,433	Workers' Compensation Insurance	\$	77,228	IDPH License Fee	\$ 1,990
Renita Foster	Assist. Administrator	0	40,789	Unemployment Compensation Insurance		39,800	Advertising: Employee Recruitment	5,935
Rick Duros	Administrative	0	26,266	FICA Taxes		271,493	Health Care Worker Background Check	645
Arnold Kanter	Administrative	0	48,360	Employee Health Insurance		207,195	(Indicate # of checks performed 54 )	
Paul Magit	Administrative	7.05	25,000	Employee Meals		10,512	Dues & Subscriptions	337
John Schlofrock	Administrative	5.52	23,333	Illinois Municipal Retirement Fund (IMRF)*			Licenses & Fees	2,941
See Supplemental Schedule			32,356	Chicago Head Tax		5,664	Dues - ILCLTC (ADJ COPE)	3,693
TOTAL (agree to Schedule V, line 17, col. 1)				401K Plan		15,540	Barton Healthcare Allocation	43
(List each licensed administrator separately.)			\$ 294,537	Employee Uniforms		4,893	Barton Management Allocation	7
B. Administrative - Other				Misc. Employee Benefits		789	Less: Public Relations Expense	( )
Description			Amount	Christmas Expense		5,888	Non-allowable advertising	( )
Management Fees			\$ 873,051	Union Pension		22,026	Yellow page advertising	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 873,051	TOTAL (agree to Schedule V, line 22, col.8)			\$ 661,028	TOTAL (agree to Sch. V, line 20, col. 8)
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost Ruttenberg & Rothblatt	Accounting		\$ 9,600				Out-of-State Travel	\$
Bisys Retirement Services	Accounting		1,600					
Pension Performance	Accounting		2,526					
Barton Management	Accounting		790				In-State Travel	
Alpha Data Services	Payroll - Data Processing		4,645					
Enloe Drugs	Software Support		1,800					
Barton Management	Computer Consulting		7,774					
Count Me In	Software Support		356				Seminar Expense	2,188
Barton Management	Adjusted Out On Pg. 5		63,593					
Barton Management	Legal (Adjusted On Pg. 5)		143					
Personnel Planners	Unemployment Consult.		1,974					
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 94,801				TOTAL	\$ 2,188

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Clayton Residential Home

STATE OF ILLINOIS

# 0016634

Report Period Beginning: 01/01/05

Ending: 12/31/05

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XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

Yes  
ILCLTC - \$6,856

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

Yes  
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

No  
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

Yes  
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ N/A  
Line N/A

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

No  
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 135,233

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

No

SEE ACCOUNTANTS' COMPILATION REPORT

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

No

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)  
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ 10,512  
No  
Indicate the amount. \$ N/A

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

No  
No  
N/A  
100% Ln 14  
Yes  
No  
No  
No  
No  
No  
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

No  
N/A  
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees.

N/A